

Using Training in Verbal Skills to Reduce the Use of Seclusion and Restraint

By Linda Witte

"It's not possible to be seclusion/restraint free with a mentally ill population."

"The patients will rule the units and things will be out of control if we don't use seclusion and restraint."

"Staff will suffer more injuries."

"We don't have time within our shifts to spend on increased verbal interactions."

Sound familiar? Those same concerns were expressed by Pine Rest staff last winter when rumors of a change in practice were circulating throughout the organization.

Pine Rest Christian Mental Health Services (PRCMHS) is a recognized leader in mental health care and is one of Michigan's largest organizations providing a continuum of services for all ages. First established in 1910, PRCMHS currently serves approximately 187,000 annual patient visits for outpatient care and 5,600 inpatient admissions. In addition, PRCMHS maintains a census of 79 residents in a residential program for people with Developmental Disabilities, 66 residents in an Adolescent Residential Care program, and 135 residents in an Addiction Services Residential program. PRCMHS has dedicated itself to expressing the healing ministry of Jesus Christ through professional excellence, Christian integrity, and compassion. It has always been recognized for

high standards of treatment, but the organization knew it could improve in the area of reducing rates of seclusion and restraint.

PRCMHS executive leadership initiated the process of reducing rates of seclusion and restraint by focusing on one inpatient unit. The Child and Adolescent Unit (C&A) was chosen largely because the unit showed the greatest increase in numbers of seclusion and restraint over the last few years. Leadership appointed a task force comprised of the Director of Operations for Hospital Based Services, the Clinical Services Manager, a psychiatrist, a case manager (social worker), the lead RN, two direct caregivers, the Director of Clinical Practice, and the Staff Educator. The directive given was to formulate a strategy for reducing seclusion and restraint and begin implementation of the strategy on C&A.

At one of the initial meetings, the case manager volunteered to collect data on all seclusion and restraint episodes for the past three years. It was felt that in order to move ahead, the Task Force needed to better understand the events that occurred in the past. Data collected included identifying the number of seclusion and restraint episodes as well as the number of different patients involved. **Figure 1** shows data reflecting the number of seclusion and restraint episodes per number of beds over the last three years.

About the Author

In her 25 years of employment at Pine Rest Christian Mental Health



Services, Linda Witte has served in various positions. She is currently the Staff Educator for Hospital Based Services. Linda received a degree in psychology from Calvin College in Grand Rapids Michigan. She is a Senior Associate Level Certified Instructor for the Crisis Prevention Institute.

The data reflected to the Task Force that changes in our practice were necessary. Despite no increases in the number of beds the past two years, seclusion and restraint episodes continued to increase.

The Staff Educator contacted Kendra Stea, Associate Director of Implementation at the Crisis Prevention Institute, for advice and guidance. She directed the Task Force to several reference sources and advised the Task Force to direct initial focus on the debriefing process. Stea advised that starting with an exploration of our debriefing process would help the Task Force to identify the patient's perspective and evaluate staff practice. Stea also recommended implementing CPI's *Enhancing Verbal Skills: Applications of Life Space Crisis Intervention*SM training. The Task Force reviewed the materials and recommendations and decided to adopt this approach. As a result, the Task Force began a process of implementation.

1. The paperwork used in crisis situations was redesigned with the goals of prompting staff through the process of debriefing, increasing staff's understanding of the perspective of the patient, and making necessary information more accessible to all disciplines.
2. The Task Force applied for a grant to fund the Staff Educator, the Task Force, and, within a few months, all C&A staff to receive CPI's *Enhancing Verbal Skills: Applications of Life Space Crisis Intervention*SM training. The grant request was quickly approved by senior management.

Figure 1: Incidents at child and adolescent unit

Year	# of Beds	S/R Episodes	# of Patients Involved in Episodes
2004	25	105	25
2005	36	193	58
2006	36	240	92
01/31/2007-07/01/2007	36	5	5

3. Senior management presented the Task Force members to their peers as leaders modeling a different way of approaching patients. Task Force members modeled and coached peers through crisis moments.
4. Case managers implemented a practice of developing specific treatment plans for patients at least once daily.
5. Direct caregivers were encouraged to notify psychiatrists as soon as a change in attitude or behavior was noted so the practice of giving "as needed" medications took a more proactive approach.
6. Staff began briefly consulting with each other prior to approaching a patient in crisis. This practice enabled staff to focus on the individual's treatment plan, brainstorm creative alternatives in the choices offered to patients in crisis, and provide consistent, professional interactions with an individual in crisis.
7. Unit routine and structure was examined to see where flexibility and individual choice could be incorporated.
8. Staff were encouraged to reflect on their interactions with patients and possible patient perceptions of how the staff member presented him- or herself. Staff were also encouraged to solicit feedback from peers

regarding how they were perceived by those around them.

Initial results have been very encouraging. Between January 31 and July 1, 2007, the number of seclusion and restraint episodes dropped to a total of five. The unit was seclusion-free and restraint-free for 76 consecutive days within that time period. The Performance Improvement Auditor for Seclusion and Restraint reports no significant change in the number of "as needed" medications being given. Additionally, the rate of staff injuries occurring as a result of patient care, as evidenced in **Figure 2**, has not increased.

Because the initiatives started in 2007 are currently being implemented in only one unit, a comparison over the same time period can be made with another unit not currently participating in the initiatives at time of publication. The Mulder West Unit, a smaller inpatient unit serving a chronically mentally ill population has seen slightly fewer episodes of seclusion and restraint, as seen in **Figure 3**. This is a non-equivalent comparison group, however, as patient stays are typically longer (approximately 20 days rather than five days on the Child and Adolescent Unit) and repeat admissions are more common.

Figure 2: Staff injuries due to patient care at child and adolescent unit

Date Range	First Quarter 2006	Second Quarter 2006	Third Quarter 2006	Fourth Quarter 2006	First Quarter 2007*	Second Quarter 2007*
Injuries	24	14	26	23	17	24
Patient Days	2,463	2,238	1,935	1,717	1,999	2,134
Injuries/1,000 days	9.7	6.3	13.4	13.4	8.5	11.2

*postintervention

Interestingly, some of the same concerns voiced by staff on the Child and Adolescent Unit before the initiatives were implemented are now heard from staff on the Mulder West Unit. Administrators hope to experience a major change in the culture on the Mulder West Unit when training begins and the initiative gets underway there.

Further effects from the initiatives implemented on the Child and Adolescent Unit may not be as easy to quantify. A greater flexibility about routine and structure has led to patients feeling that they are more involved in the treatment process. Patients have become involved in planning best interventions for themselves as they strive to keep from being overwhelmed by their feelings. Staff report an increase in ability of the patients to be more self-directed in calming themselves and managing aggressive feelings. One staff member reports, "The unit is more peaceful."

Staff members are reporting differences in their attitudes and practices as well. They are working more closely as a team across the disciplines. They think more creatively about alternate approaches and have redefined what constitutes "last resort." Staff attitudes have changed from, "How can we get the patient to fit into our system?" to, "How can we best meet the needs of our patient and guide our patient toward wise choices?" Staff also report having more confidence in their ability to productively use verbal skills to de-escalate situations after receiving the *Enhancing Verbal Skills: Applications of Life Space Crisis Intervention*SM training.

This transition has not been without its challenges. Staff skepticism was difficult to overcome at times. The adjustment to intentionally ignoring superficial, attention-seeking behavior was difficult for some staff. There were several episodes of initial resentment to overcome when Task Force members stepped into crisis situations. There has

Figure 3: Incidents at Mulder West Unit*

Year	# of Beds	S/R Episodes	# of Patients Involved in Episodes
2004	24	37	26
2005	24	35	23
2006	24	45	26
01/31/2007-07/01/2007	22	13	8

*nonequivalent control group

also been an increase in one-staff-to-one-patient arrangements when patients become more of a risk for harmful behavior. C&A unit staff attempt to keep these one-staff-to-one-patient arrangements as brief as possible (keeping it to a couple of hours duration is preferable) to decrease any possible additional costs to the organization.

Staff also had misperceptions to overcome. One misperception was that no *Nonviolent Physical Crisis Intervention*SM techniques were to be utilized. In practice, staff found that, as a last resort, they were able to use physical intervention techniques from The Crisis Prevention Institute's *Nonviolent Crisis Intervention*[®] and *Applied Physical Training*SM programs effectively and subsequently de-escalate the patient using the Enhancing Verbal Skills training without an incident becoming a seclusion or restraint episode. A second misperception was that management stopped admitting difficult clients. In fact, management confirms it has not been screening admissions, but rather staff do not realize that efforts to use less coercive means to deal with difficult patients has led to a more peaceful environment.

And what about those concerns expressed by staff on an earlier page? Staff on the C&A unit have now reported a realization that the goal is to significantly reduce the use of seclusion and restraint, and that they have confidence that it can be done. They have witnessed the effectiveness of using a variety of tools prior to using seclusion and restraint. By offering more choices

and placing greater emphasis on being proactive, staff have seen the advantage of involving the patients in directing the course of their treatment. Patients do not "rule the unit" in a negative way, but they have been empowered to become more directive in their own care. The C&A unit became a safer place with 37% fewer injuries than the previous quarter. Staff members also report having more time available during their shifts to spend with patients in positive, therapeutic interactions.

PRCMHS is very encouraged by the initial results of implementing these changes on the C&A unit. The next step is to incorporate this new initiative on the rest of the inpatient units. C&A staff will act as mentors to the other units by working shifts with them and helping them to incorporate key concepts into effective treatment for their populations.

There have been several key contributors to the success of our initiative. The leadership and support of senior management in setting the tone for the new directive was vital. Appointing competent, effective staff members to be on the Task Force and lead the way has been crucial. The third component to the success of the initiative is the direction and training provided by Kendra Stea and the Crisis Prevention Institute.

Our continued success will depend on consistent support from management and the dedication of staff members in continuing to implement the new structure for interacting with patients in crisis. 